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Psychotherapy for the Patient with Adult ADHD

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THE NATURE OF ATTENTION DEFICIT/HYPERACTIVITY DISORDER IN ADULTS

Attention deficit hyperactivity disorder persists (ADHD) into adult life in 10 to 60 percent of childhood cases, and is present in approximately 4.5 percent of adults. Some ADHD symptoms may persist in adults even though they no longer meet full diagnostic criteria. The typical adult with ADHD complains of difficulty getting started on tasks, variable attention to details, difficulties with self-organization and prioritization, and poor persistence in tasks that require sustained mental effort.[1–7] He or she may struggle with impulsiveness and low frustration tolerance. Hyperactivity is unusual but the person may describe a sense of inner restlessness.

Many adults with ADHD have chaotic lifestyles or have trouble at work. They may rely on drugs or alcohol to "get by," and they also often have associated psychiatric comorbidities. They are more likely to have motor vehicle accidents and receive citations for speeding. Adults with ADHD have four times the prevalence of sexually transmitted diseases and have had more teenage pregnancies. Genetics plays a major role in the development of ADHD, as do prenatal and perinatal risk factors, such as exposure to cigarettes and alcohol *in utero*, low birth weight, and brain injuries. The anatomical

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localization (if one exists) for the ADHD "lesion" is not yet certain. It may be in the frontal lobes or in other brain areas with subcortical projections. Functional magnetic resonance imaging (MRI) data show that the prefrontal cortical areas involving working memory, alerting responses, and response inhibition are less active and smaller in some adults with ADHD.[1–7]

ADHD is not an acquired disorder of adult life. To qualify for a diagnosis of ADHD as an adult one must have had it as a child, although some of the symptoms of ADHD can occur in adults due to brain injuries or other organic causes. Symptoms are present consistently since childhood and are not episodic. Impairments in function are global, not selective, and are noticeable in all spheres of life to a greater or lesser degree. Although adult ADHD is a relatively common disorder, only one third to one half of adults who believe they have ADHD actually meet formal DSM-IV-TR criteria (Table 1).

The most common psychiatric conditions that may have overlapping symptoms with adult ADHD include mood disorders, anxiety disorders, substance use disorders, antisocial personality disorder, borderline personality disorder, developmental disabilities or mental retardation, and certain medical conditions.

TABLE 1. DSM-IV-TR diagnostic criteria for attention deficit hyperactivity disorder

A. EITHER (1) OR (2):

1. Six (or more) of the following symptoms of inattention have persisted for at least 6 months in a degree that it is maladaptive and inconsistent with developmental level:
(a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
(b) often has difficulty sustaining attention in tasks or play activities
(c) often does not seem to listen when spoken to directly
(d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace
(e) often has difficulty organizing tasks and activities
(f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
(g) often loses things necessary for tasks or activities
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

2. Six (or more) of the following symptoms of hyperactivity-impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:
Hyperactivity
(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be linked to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively
Impulsivity
(g) often blurts out answers before questions have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others

B. Some hyperactive-impulsive or inattentive symptoms that caused impairment were present before the age of seven years.

C. Some impairment from the symptoms is present in two or more settings (e.g. at school (or work) and at home)

D. There must be clear evidence of clinically significant impairment in social, academic, or occupational functioning

E. The symptoms do not occur exclusively during a course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder and are not better accounted for by another mental disorder (e.g. mood disorder, anxiety disorder, dissociative disorder, or a personality disorder)

Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.* Washington, DC: American Psychiatric Press, Inc., 2000.

CLINICAL CASE #1—INITIAL PRESENTATION

Background. Tom is a 32-year-old school teacher, who has a "temper problem." He is impatient with the pupils at school and does not turn in his lesson plans on time. Coming to this psychiatric appointment was a condition of his continuing employment at the school.

Tom was "hyperactive" as a child and often caused disruption both in school and home settings. His father told teachers that his son's behavior was because "boys will be boys," but his mother noticed several differences between him and his brothers. She told teachers that he was more impulsive and that he was constantly running and climbing. She described him as being impatient with other family members and said that he had trouble adjusting to new situations. His first-grade teacher criticized him for blurting out answers and complained that he had difficulty focusing and often interrupted others. He had one or two friends but was not popular. He required redirection many times throughout the school day and was at times argumentative and resistant. Although he also was described as "very bright and imaginative," he often failed to complete assignments. He was diagnosed with ADHD and was treated successfully with methylphenidate (Ritalin®), but discontinued it around the time he

graduated from college, thinking he likely had "outgrown" his ADHD.

Tom reports a positive family history of ADHD in his mother and a paternal uncle.

Tom's symptoms as an adult. Since finishing college and starting his first teaching job, Tom describes feeling socially awkward and states, "I don't have any friends." He has chronically low self esteem and trouble adjusting to new situations. He misses appointments because he forgets. He describes conversations with others as "a chore." He also is an impatient driver and often spends money impulsively. He often interrupts others and is impulsive in his responses, at times losing his temper. He reports multiple verbal outbursts but no physical violence. Finally, the school principal advised him to seek help or risk losing his job.

out of my mouth. There is nothing wrong with my hearing, but I just don't seem to hear what other people tell me. I am drinking more, especially after a bad day at work, and I'm afraid this will get me into trouble.

A THREE-PRONGED APPROACH TO HELPING THE ADULT WITH ADHD: MEDICATION, EDUCATION, AND PSYCHOTHERAPY

Medications for adult ADHD. Adult patients who respond to medications that are used in the treatment of ADHD may expect enhanced attention, better academic performance, and facilitated working memory.[8] These medications can reduce psychomotor activity and decrease aggression and disruptive behavior; however, residual symptoms may persist at a lower level.

disorders can be treated simultaneously with a second-line ADHD medication (e.g., an antidepressant). Second-line agents may offer the advantages of once-daily dosing or may allow less frequent office visits because refills can be written on the prescription.

Patient education. Information is an important tool in the treatment of ADHD in an adult. Educational literature about ADHD should be handed out to patients, partners, and family members where appropriate, and arrangements should be made to meet with partners or families separately to address their specific problems and issues when needed.

Tom's self-esteem improved when he realized that many of the problems he had experienced stemmed from a medical disorder rather than "laziness" or character defects. It is helpful to

A THREE-PRONGED APPROACH should be used to help the adult with ADHD: Medication, education, and psychotherapy.

INITIAL INTERVIEW WITH TOM

Tom: I thought the ADHD was gone. It was something I had as a kid. I'm embarrassed to be here now, but I can't lose my job. The principal at the school where I teach is worried about me.

Psychiatrist: It was a good decision to have come in today. Tell me more about your work situation…

Tom interrupts and speaks rapidly...

Tom: It's not just the work. I haven't made any friends since I left college. I seem to either avoid people altogether, or I annoy them. I struggle to make conversation, you know, small talk. I'm frustrated, and you've got to help me.

Psychiatrist: Tell me what happens when you get frustrated.

Tom: I lose it. I mean, I have no patience for people, including the children in my classroom. I find myself saying things without thinking and then regretting it. Sometimes things just seem to fly

Stimulants, norepinephrine reuptake inhibitors, norepinephrine-serotonin reuptake inhibitors, and norepinephrine-dopamine reuptake inhibitors are the most widely used treatments for adult ADHD.[9–11]

Psychostimulants remain the commonly recommended treatment for adult ADHD, and they improve both behavioral and cognitive aspects of the disorder in the majority of patients.[8,12] There is a 60- to 80-percent response rate to these drugs. Recently, alternative agents have been substituted due to less need for laboratory retesting and little addiction potential, particularly since a number of adult ADHD patients have a co-occurring substance use disorder.[12] Agents other than psychostimulants also should be considered when there is inadequate response to psychostimulants or when they are not tolerated because of side effects. Alternative agents also may be considered if there is a coexisting psychiatric disorder and both

suggest coping strategies, such as making lists of things to do everyday, breaking up large assignments into small tasks, using a calendar or computerized schedule to help plan and organize, working in a quiet area without windows, and arriving at work before coworkers. Tom was advised to create a routine, exercise regularly, and get sufficient sleep. Tom learned to make notes to summarize reading material to decrease the span of attention needed to review a text. He was advised to take short but frequent breaks after about 20 minutes of reading in order to process what has been read, especially when the material is detailed or novel. Tom learned to write questions regarding the material to assist attention, and thereby helping his understanding and comprehension. Tom also found a number of websites that were available that offered information for adults with ADHD.

Supportive, cognitive, behavioral, and interpersonal

psychotherapy. The symptoms of adult ADHD itself do not respond well to psychotherapeutic interventions alone. However, supportive psychotherapy (which enhances the patient's pre-existing coping skills) and cognitive behavior therapy (which is a learning experience in which the therapist plays an active role in helping patients to recognize, identify, and modify cognitive biases that cause distress and impede constructive problem solving) may be useful in adults with ADHD and help these individuals with organization and planning, coping with distractibility, and cognitive restructuring. The latter involves learning skills to maximize adaptive thinking during stress and also to apply adaptive thinking skills to difficulties associated with ADHD if there are concomitant personal issues, such as a sense of failure, low self esteem, frequent job changes, or other disturbances in sense of identity or relationships with others that relate to the person's efforts to deal with ADHD symptoms.

CLINICAL CASE #2—INITIAL PRESENTATION

Lynn, a 24-year-old graduate student, presented with academic struggles and relationship discord and requested help from a psychiatrist.

Growing up, Lynn had difficulty making friends and always felt inadequate in school. She felt she put more time into her school work relative to other students in her class and had poor grades despite her efforts. When teachers recommended evaluation for possible ADHD in second grade, her parents refused and believed she simply needed to try harder and that her poor grades were the result of lack of commitment. Lynn struggled with self-esteem issues and as she reached early adolescence, she began experiencing feelings of inadequacy, especially when her school required public speaking, group work, or extensive interface with other students who tended to tease and taunt her. Throughout her teenage years, Lynn struggled with sustaining relationships. Despite the fact that she seemed extroverted, she felt she irritated and annoyed others, and at times this was expressed to her in no uncertain terms.

She saw a therapist briefly at age 19, but did not feel she "connected" with this person and terminated the relationship after just a few sessions. Subsequently, Lynn had a series of conflicted relationships and most often did not fully understand why they ended, nor did she process the losses. She requested psychotherapy at this time, stating she was not currently in a relationship with a significant other, but feared she had not "learned" from previous mistakes and feared she sabotaged any potential relationships with nonverbal communication, giving the message to others that she is unavailable.

TABLE 2. Goals of supportive psychotherapy

- **Reducing behavioral dysfunctions**
- **Reducing subjective mental distress**
- **Supporting and enhancing the patient's strengths and coping skills, and his or her capacity to use environmental supports**
- **Maximizing treatment autonomy**
- **Achieving maximum possible independence from psychiatric illness**

Source: Novalis PN, Rojcewicz SJ, Peele R. *Clinical Manual of Supportive Psychotherapy.* Washington, DC: American Psychiatric Press, Inc., 1993:7.

PRACTICE POINT: EXAMPLE OF SUPPORTIVE PSYCHOTHERAPY INTERVENTION WITH LYNN

Psychiatrist: Tell me about your academic struggles.

Lynn: I am doing some graduate work, and while I have always done well in my area of interest, I find that with a full load of coursework, I begin to become overwhelmed, start several things at the same time, and then end up not completing any one task. I get so far behind I feel I cannot catch up. I start to panic and worry. It always appears to me that other students can put in less effort and get better grades.

Psychiatrist: It sounds as if this feels like a pattern you have experienced before with your academic work.

Lynn: Same old thing, just different semester. I am just not sure how to manage the anxiety while attempting to get the school work completed.

Psychiatrist: What are some ways you have coped with anxiety in the past? How are you coping with the anxiety right now?

In the supportive psychotherapy model, the psychiatrist will attempt to reduce subjective mental distress and identify the patient's current coping skills so that healthy strategies can be optimized and symptoms are better controlled acutely. Lynn needed assistance with time management and organization of multiple tasks presented to her at one time.

Supportive psychotherapy is patient-driven, symptom-focused, and empirical. The immediate goal of Lynn's therapy at this time included a plan for control of anxiety and management of her coursework. In the future, she may benefit from long-term characterological change, but that was not the most important goal of therapy at this time. (Table 2).

PRACTICE POINT: EXAMPLE OF INTERPERSONAL PSYCHOTHERAPY INTERVENTION WITH LYNN

Interpersonal psychotherapy addresses issues that may have developed between the patient and other people due to misunderstandings about adult ADHD symptoms. It also helps individuals with concomitant personal issues, such as a sense of failure, low self esteem, frequent job changes, or other disturbances in sense of identity or relationships with others that relate to the person's efforts to deal with ADHD symptoms.

Psychiatrist: Tell me about your most recent relationship.

Lynn: I was dating Sam for about two years; we met at school, and at first it seemed we had a lot in common.

We did things as a couple but also in a group of friends. When some of the friends moved into other programs, we spent more time together exclusively. At this point it seemed like he became annoyed with me more and more, and giving me similar feedback as previous boyfriends.

Psychiatrist: Tell me more about that feedback.

Lynn: I lose things all the time, I am late for everything, and I don't stand up for myself, always apologizing.

Psychiatrist: Why always apologizing?

Lynn: I think what happens is I sense pretty early on that I frustrate people with my interrupting, my forgetfulness, and procrastination. I try to make up for it by pleasing them, by giving in, avoiding decisions, being a "pushover." This certainly is not attractive, and then compounds the problem.

The psychiatrist is active and often directive in interpersonal psychotherapy, exploring the relationship issues in detail, and identifying one or two specific problems as the foci of the therapeutic work.[13]

In interpersonal psychotherapy, the treatment usually lasts 12 to 16 sessions. In the early stages the therapist is in an exploratory mode, eliciting descriptions of the patient's relationships and seeking to identify the foci of the work. Through encouragement of affect, the therapist assists the patient in recognizing unpleasant emotions, expressing them, and modulating them in interpersonal contexts.[13] Many patients are fearful of experiencing and expressing anger and frustration within important relationships. They feel they may put relationships at risk by expressing themselves.

The therapist uses a great deal of clarification to encourage the expression of affect. At times it may take the form of reframing; at other times the therapist may clarify the disjunction between the patient's inner experience and what is communicated to important others.[13] In the case of the adult patient with ADHD, it is important to take into account the symptoms of the disorder and incorporate their effects on interpersonal relationships.

SUMMARY

Psychotherapy alone is not an effective treatment for the symptoms of ADHD, but may be useful in adults with ADHD if there are concomitant personal issues, such as a sense of failure, low self esteem, frequent job changes or other disturbances in sense of identity or relationships with others. Patients with ADHD have difficulties in interpersonal relationships at home and at work, commonly resulting in criticism and rejection. A skilled therapist can assist the patient to understand and work through past experiences and improve functioning in these areas. Because other psychiatric disorders are significantly more common in adults with ADHD than in other populations, these comorbidities may need to be clarified and reconsidered in the differential diagnosis during the course of therapy as well.[14–16]

PSYCHOTHERAPY ALONE is not an effective treatment for the symptoms of ADHD, but may be useful in adults with ADHD if there are concomitant personal issues, such as a sense of failure, low self esteem, frequent job changes, or other disturbances in sense of identity or relationships with others.

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